OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

ARTMENT OF MENTAL HEALTH
9th STREET
MENTO, CA 95814

(916) 323-8176

January 7, 1991

DMH INFORMATION NOTICE NO.: 91-02

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, MENTAL HEALTH ADVISORY BOARDS

SUBJECT: Informed Consent Form for Electroconvulsive Treatment

Sections 5325 through 5327 of the Welfare and Institutions Code require that there will be an informed consent form signed by a patient who is to receive Electroconvulsive Treatment (ECT).

A form was developed by the Department for use with patients who are to receive ECT. The form [MH 300 (8/89)] is titled Electroconvulsive Treatment (ECT), Informed Consent For. This form is available in English and in Spanish.

Copies of this form may be obtained from the Records Management Unit, Department of Mental Health, 1600 9th Street, Room 100, Sacramento, California 95814.

Thomas E. Rietz

THOMAS E. RIETZ
Deputy Director
Division of Community Programs

Enclosure

cc: California Council on Mental Health
Chief, Community Program Operations Branch
County Operations Chiefs

DO NOT SIGN THIS FORM UNTIL YOU HAVE ALL THE INFORMATION YOU DESIRE CONCERNING ELECTROCONVULSIVE TREATMENT (ECT).

The nature and seriousness of my mental condition, for which ECT is being recommended, is _____

_____

RECOMMENDATION: I understand that ECT involves passage of an electrical stimulus across my brain for a few seconds, sufficient to induce a seizure. In my case the treatments will probably be given_____ times per week for_____weeks, not to exceed a total of_____treatments and not to exceed 30 days from the first treatment. Additional treatments cannot be given without my written consent.

Reasonable alternative treatments (such as psychotherapy and/or medication) have been considered and are not presently recommended by my doctor because

IMPROVEMENT: I understand that ECT may end or reduce depression, agitation and disturbing thoughts. In my case there may be permanent improvement, no improvement, or the improvement may last only a few months. Without this treatment my condition may improve, worsen or continue with little or no change.

SIDE EFFECTS AND RISKS: I understand there is a division of opinion as to the effectiveness of this treatment as well as uncertainty as to how this proceedure works.

I also understand this treatment may have brief side effects; headaches, muscle soreness and confusion.

There may be some memory loss which could last less than an hour or there may be a permanent spotty memory loss. Memory loss and confusion may be lessened by the use of unilateral (one-sided) electrical brain stimulation rather than bilateral (two-sided) stimulation.

Anesthesia and muscle relaxants will be used during these treatments to prevent accidental injury. Oxygen will be administered to minimize the small risk of heart, lung, brain malfunction or death as a result of the anesthesia or treatment procedures.

My physician states I have the following special circumstances which increase the risk in my case:

I HAVE THE RIGHT TO ACCEPT OR REFUSE THIS TREATMENT. IF I CONSENT, I HAVE THE RIGHT TO REVOKE MY CONSENT FOR ANY REASON AT ANY TIME PRIOR TO OR BETWEEN TREATMENTS.

Dr. _____has explained the above information to my satisfaction. At least 24 hours have elapsed since the above information was explained to me. I have carefully read this form or had it read to me and understand it and the information given to me.

I HEREBY CONSENT TO ECT._____

Signature Date and Time

_____

Witness Signature

Box

] I am aware that I am entitled to speak with a patients' rights advocate before and/or after treatment.

NT FOR PATIENTS DEEMED TO HAVE THE CAPACITY TO CONSENT

have carefully read and understand the foregoing information. I hereby consent to the performance electroconvulsive therapy. The required 24 hours have elapsed between the time the foregoing formation was provided to me and my signature.

(Patient's Signature) (Date and Time)

(Witness, other than attending or treating physician)

NT FOR PATIENTS DEEMED NOT TO HAVE THE CAPACITY TO CONSENT

ave carefully read and understand the foregoing information. I hereby consent to the performance

electroconvulsive treatment on: _____
(Patient's Name)

e required 24 hours have elapsed between the time the foregoing information was provided to me and y signature.

(Substitute Decision Maker) (Date and Time)

(Legal or Familial Relationship to Patient) (Date and Time)

CATION OF RESPONSIBLE RELATIVE

tial appropriate box:

] I hereby request that no relative be notified of my treatment by electroconvulsive therapy.

] I hereby request that _____ be notified of my treatment
(Responsible Relative)

by electroconvulsive therapy.

(Patient's Signature) (Date and Time)

(Witness)

ELECTROCONVULSIVE TREATMENT
INFORMED CONSENT

Confidential Patient Information
See W&I Code Section 5328

My signature and the time the above information was provided to me.

Date _____ Patient _____

Date _____ Witness _____

I understand that while the understanding and consent of a relative or guardian to electroconvulsive therapy is desirable, I may invoke my right to privacy and request that no relative or guardian be notified of this treatment.

Initial Appropriate Box

/__/ I hereby request that no relative or guardian be notified of my treatment by electroconvulsive therapy.

/__/ I hereby authorize and agree that a relative or guardian may be notified of my treatment by electroconvulsive therapy.

Date _____ Patient _____

Date _____ Witness _____

CONSENT OF RELATIVE OR GUARDIAN

I have carefully read and understand the foregoing consent form. Dr._____ _____has explained to me the nature of electroconvulsive treatment alternative therapies, and the possible risks of such treatment. I join in consent to the performance of electroconvulsive therapy upon _____ _____.

Date _____ Relative or Guardian _____

LACDMH/1292